DOCUMENT RESUME

ED 360 311 SP 034 721

TITLE	Lessons from the Classroom: Elements of Promising School-Based HIV Education Programs and Recommendations for State Education Agencies.
INSTITUTION	Council of Chief State School Officers, Washington, DC. Resource Center on Educational Equity.
SPONS AGENCY	Centers for Disease Control (DHHS), Atlanta, GA. Div. of Adolescent and School Health.
PUB DATE	92
CONTRACT	U63-CCU-302851-02
NOTE	82p.
AVAILABLE FROM	Council of Chief State School Officers, Resource Center on Educational Equity, One Massachusetts Avenue, N.W., Suite 700, Washington, DC 20001-1431 ($10).
PUB TYPE	Reports - Descriptive (141) -- Reports - Research/Technical (143)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Acquired Immune Deficiency Syndrome; Classrooms; Educational Practices; Elementary Secondary Education; *Health Education; Health Promotion; *Observational Learning; Policy Formation; Program Content; *Program Effectiveness; Program Evaluation; Public Schools; *School Activities; School Districts; State Departments of Education
IDENTIFIERS	*Comprehensive School Health Programs; Site Visits

ABSTRACT

In 1987, the Council of Chief State School Officers (CCSSO) initiated a Human Immunodeficiency Virus (HIV) Education Project to enhance the capacity of state education agencies to assist local education agencies and schools in implementing effective HIV education within a framework of a comprehensive school health program. This publication, the result of school site visits conducted by CCSSO project staff during 1989 and 1990, reports on a number of schools' HIV prevention programs. Lessons about effective HIV education programs and what promotes learning were derived from classroom observations of promising HIV education programs. Following an introduction, the document offers recommendations intended to inform state efforts for enhancing students' healthy development and academic performance based on suggestions of administrators, faculty, and students who were interviewed during site visits. The main body of the document consists of a section titled "Common Elements of Promising Programs" and an appendix highlighting schools visited and the status of HIV and health in their districts. A list of 31 resources and 21 references are included. (LL)

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Lessons from the Classroom

Elements of Promising School-Based HIV Education Programs and Recommendations for State Education Agencies

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FROM THE
CLASSROOM

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This publication was completed with fiscal and technical assistance provided by a cooperative agreement (Number U63-CCU-302851-02) with the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, Atlanta, GA 30333. This publication has been reviewed and approved by CCSSO's HIV/AIDS Review Panel for the use of chief state school officers and state education agencies.

THE COUNCIL OF CHIEF STATE SCHOOL OFFICERS (CCSSO)

The Council of Chief State School Officers (CCSSO) is a nationwide nonprofit organization of the 57 public officials who head departments of public education in every state, the District of Columbia, the Department of Defense Dependents Schools, and five extra-state jurisdictions. CCSSO seeks its members' consensus on major education issues and expresses their views to civic and professional organizations, to federal agencies, to Congress, and to the public. Through its structure of committees and task forces, the Council responds to a broad range of concerns about education and provides leadership on major education issues.

Because the Council represents the chief education administrators, it has access to the educational and governmental establishment in each state and to the national influence that accompanies this unique position. CCSSO forms coalitions with many other education organizations and is able to provide leadership for a variety of policy concerns that affect elementary and secondary education. Thus, CCSSO members are able to act cooperatively on matters vital to the education of America's young people.

The CCSSO Resource Center on Educational Equity provides services designed to achieve equity and high-quality education for minorities, women and girls, and for the disabled, limited English proficient, and low-income students. The Center is responsible for managing and staffing a variety of CCSSO leadership initiatives to assure education success for all children and youth, especially those placed at risk of school failure.

Council of Chief State School Officers

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PREFACE

With a five-year cooperative agreement from the Centers for Disease Control, the Council of Chief State School Officers (CCSSO) initiated an HIV Education Project in October 1987.[1] Situated in the Resource Center on Educational Equity, the HIV Education Project is part of the overall CCSSO effort to support chief state school officers and their staffs as they seek to ensure the healthy development and educational success of all students.

Goal of CCSSO's HIV Education Project

The goal of CCSSO's HIV Education Project is to enhance the capacity of state education agencies (SEAs) to assist local education agencies (LEAs) and schools in implementing effective HIV education within a framework of a comprehensive school health program. Since the initiation of the project, CCSSO staff have studied HIV education policies and programs, analyzed research about effective strategies for enabling youth to engage in healthful behaviors and make life-enhancing decisions, and explored how restructuring schools and how students are taught might positively affect HIV education programs.

As part of this project, CCSSO has produced a series of publications. The first, *How Four States Put HIV/AIDS Instruction in the Classroom* (1990), highlighted how four diverse states—Alabama, Maryland, Nebraska, and Washington—provided instruction about HIV infection and AIDS in elementary and secondary classrooms. The second, *Beyond the Health Room* (1991), provided a rationale for schools to take leadership in improving the health of children and youth by examining the relationship between health and learning; the health needs of our nation's youth; the building blocks of a comprehensive school health program; and the implications of the HIV epidemic for school health programs. This document, *Lessons from the Classroom*, is the third book in this series.

Lessons from the Classroom reports on a number of schools' HIV prevention programs. It is the result of school site visits conducted by CCSSO staff during 1989 and 1990 to observe promising HIV education programs, and it builds on four years of CCSSO experience examining how school health programs foster positive health behaviors. It contains (a) elements identified as crucial to successful HIV prevention programs and (b) recommendations to strengthen SEAs' roles in promoting HIV prevention programs within comprehensive school health programs.

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[1] The report frequently uses the term HIV (human immunodeficiency virus) rather than AIDS, because preventing infection with HIV is the key to controlling the epidemic. AIDS (acquired immunodeficiency syndrome) is the end stage of infection with HIV. HIV damages the immune system and eventually impairs its function. People infected with HIV are diagnosed as having AIDS if their T-cell count drops below a certain level or if they develop certain serious conditions, including *Pneumocystis carinii* pneumonia, HIV dementia, or Kaposi's sarcoma (a form of cancer).

Objectives of Lessons from the Classroom

For the past several years, CCSSO has examined promising approaches and practices that schools use to provide HIV education for their students. CCSSO's objectives for the site visits were to

- identify and describe promising HIV education programs and the factors critical to their success.
- recommend ways that SEA policymakers and program specialists could use that information to strengthen HIV education efforts within their states.

To accomplish these objectives, CCSSO Resource Center staff visited 24 schools in 15 districts around the country during 1989 and 1990. We chose sites based on recommendations of state and local education staff who work in the area of school health. The majority of these programs were begun in the mid or late 1980s and are still being refined and revised. At the time of our visits, little research existed that described the long-term effectiveness of HIV education programs in reducing the incidence of HIV infection or in preventing risky behaviors among youth. Because of the absence of such data, CCSSO uses the term "promising" rather than "exemplary" in referring to HIV programs included in this report.

During site visits, CCSSO staff asked faculty and school administrators what they considered to be effective HIV education practices; looked at HIV/AIDS curricula and methods of instruction; discussed accountability for learning outcomes; and examined policy development, partnerships with families and the community, sound leadership, the school environment, and the availability of health and social services. In addition, site visits provided district and school staff with opportunities to suggest how state education agencies could further assist them in providing quality HIV education programs.

Goals of site visits

The goals of our visits were to

- observe HIV/AIDS instruction in classrooms.
- identify the range of strategies used for HIV education.
- determine to what degree HIV education takes place within the framework of a comprehensive school health program.
- identify critical elements of promising school HIV education programs.
- solicit recommendations for chief state school officers and SEA staff about actions they can take to improve HIV education programs as an integral part of an SEA's effort to improve educational outcomes and well-being for all students.

Site selection

CCSSO asked state and local education agency staff to identify schools in their areas that they felt had effective HIV education programs, that served a large percentage of low-income and minority youth, and that used interesting and innovative educational strategies. In addition, we wanted to find several sites that included HIV education as part of a comprehensive health program, and we sought geographic distribution of schools nationwide.

In selecting promising HIV programs, CCSSO staff looked for programs designed to

- provide students with HIV education before they engaged in behaviors that put them at risk.
- reinforce messages about HIV infection and AIDS that could influence behaviors.
- provide opportunities for students to build the skills they need to make life-enhancing decisions for now and for the future.
- recognize the needs of adolescents, their ability to perceive risk, and their willingness to act on health promotion messages.
- remain sensitive to students' developmental stages and cultural backgrounds.
- consider the whole child and re-examine ways that school health programs contribute to the school's overall effort to promote effective learning and positive student outcomes.
- build students' negotiation and communication skills and self-confidence in order to make informed, healthful decisions.
- involve educators, parents, and school and community health professionals to meet students' total needs.
- function as part of an overall school effort to support the academic success, health, and well-being of all children.

Conducting the site visits

Prior to each site visit, CCSSO staff collected demographic information about the school. During the visit, staff collected curriculum materials and guides, training materials, and any documents that described or assessed the programs observed. Wherever possible, site visits consisted of formal interviews with state and district school administrators and teachers responsible for supervision and delivery of health education, classroom observations of HIV instruction, and conversations with students and with community service providers involved with the program. In some instances, a site visit also included participation in a special event related to a site's HIV education program, such as a health fair or drama.

Each site visit occurred over a two-day period. During formal interviews, CCSSO school-site interviewers used a guide developed by the HIV Education Project staff in consultation with CCSSO's State Education Assessment Center. The guide contained three parts: one for use with school staff, one for district staff, and one for state education agency staff.

At the school level, questions explored curricular, implementation, and evaluation issues, as well as the perceived role of the state education agency. Curricular questions inquired about goals; existence of a written curriculum; teaching strategies; racial, ethnic, language, and gender sensitivities; and student outcome measures. Implementation questions probed the relationship of HIV prevention programs to existing comprehensive school health programs, funding, resource availability, origins of the program, staffing, and staff training. Evaluation questions asked about which and how many students received HIV education, how instruction was delivered, how much time HIV prevention programs took, and student outcomes.

At the district level, questions focused on how districts initiated, developed, and supported HIV prevention programs.

At the state level, interviewers discussed policy issues and the state's role in assisting, monitoring, and evaluating local programs.

ACKNOWLEDGMENTS

People who contributed directly to the success of the CCSSO Project and to this report were Jane Kratovil, Director of the HIV Education Project; HIV Education Project Associates Darlene Saunders, Bill Shepardson, and Karen VanLandeghem; Project Assistant Martha Bush; Cynthia G. Brown, Director of the Resource Center on Educational Equity; and Gordon M. Ambach, Executive Director of the Council of Chief State School Officers. The people who conducted the individual school site visits and prepared reports of their observations, interviews, and analyses of information collected were CCSSO staff members Ellen Bach, Cynthia G. Brown, Barbara Gomez, Jane Kratovil, Janet Levy, Glenda Partee, Darlene Saunders, Diane Schilder, Bill Shepardson, Leslie Talbot, and Karen VanLandeghem. This final report was written by the HIV Education Project staff and project consultant Linda Brown Warren.

Special thanks goes to the following for their assistance with advisory and technical support: the Program Review Panel of the CCSSO HIV Education Project whose members are Catherine Balsley (Coordinator for HIV Education, School District of Philadelphia), Tim Dunn (Associate Director, Center for Health Promotion and Education, Education Development Center, Inc.), Katherine Fraser (Senior Associate, National Association of State Boards of Education), Russell G. Henke (Coordinator of Health Education, Montgomery County Public Schools), Ric Loya (Health Teacher and Executive Secretary, California Association of School Health Educators), Alberto Mata (Special Expert, National Institute on Drug Abuse), Randall Pope (Chief, Special Office on AIDS Prevention, Center for Health Promotion, Michigan Department of Health), John Seffrin (Executive Vice President and CEO, American Cancer Society; formerly Chair, Department of Applied Health Science, Indiana University), Stephen B. Thomas (Director, Minority Health Research Laboratory, University of Maryland), and Edith Vincent (State Supervisor of Health Education Health Services, Delaware Department of Public Instruction); the CCSSO National HIV Education Task Force, whose members were Diane Bishop (Superintendent of Public Instruction, Arizona Department of Education), Troy Earhart (former Commissioner of Education, Rhode Island Department of Education), Kristine Gebbie (Director, Washington Department of Health), William Kirby (former Commissioner of Education, Texas Education Agency), Lloyd Novick (Director, Center for Community Health, New York Department of Health), Werner Rogers (Superintendent of Schools, Georgia Department of Education), and Denman Scott (Director of Health, Rhode Island Department of Health); and the Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, whose staff includes Lloyd J. Kolbe (Director, Division of Adolescent and School Health), Jack T. Jones (Chief, Program Development and Services Branch), David Poehler (School Health Education Specialist), Beth Broyles (Chief, Program Support Section), Wanda Jubb (Comprehensive School Health Coordinator), and Susan Wooley (Health Education Specialist).

Finally, and most of all, gratitude is extended to state, district, and school personnel; students; and the many caring people in community organizations who are working to help youth make healthy, life-enhancing choices.

INTRODUCTION

Why focus on HIV/AIDS prevention programs?

HIV is epidemic in the United States. By the end of February 1992, 213,641 cases of AIDS in the United States had been reported to the Centers for Disease Control. At the time of diagnosis, 3,598 of those cases were in children less than 13 years old, 9,210 cases were in adolescents and young adults aged 13–24 years, and 200,833 cases were in adults 25 or older. (CDC, 1992b) Because of the 10-year average incubation period for AIDS, many young adults who have AIDS were infected with HIV as adolescents.

Many of the behaviors that place people at risk for HIV infection begin during adolescence. It is a time of exploration and experimentation as youth seek to develop their own identities and be accepted by others—particularly peers.

Those traits that characterize adolescent development and assist in the transition to adulthood, including mutual dependence, valuing friendships, risk taking, and an openness to new experiences, are also the very traits that can place adolescents at risk of serious health problems, including sexually transmitted diseases and HIV infection. Many adolescents see themselves as invulnerable; they often act on impulse and are unconcerned about the consequences. Adolescents are faced with pressures from peers and the media to use alcohol and other drugs and to have sexual experiences at an early age.

In 1990 CDC conducted a national survey of students in grades 9–12—the Youth Risk Behavior Survey. Fifty-four percent of those surveyed reported having had sexual intercourse at least once. Of those who were sexually active, less than half (44.9 percent) had used condoms. (CDC, 1992a) Some 2.5 million teens contract a sexually transmitted disease each year. (CDC, 1989) According to a 1990 U.S. Department of Health and Human Services survey of high school seniors, 90 percent had consumed alcohol at least once. Nearly half (48 percent) reported having used an illicit drug.[1] Sixty percent of the seniors reported first using alcohol in the ninth grade or earlier. (U.S. Department of Health and Human Services, 1991) Because drugs impair the ability to make responsible decisions, especially in sexual situations, the use of drugs—including alcohol—is a potential link to HIV infection in the adolescent population.

Given relevant information and taught the necessary skills within a supportive environment, many adolescents are able to resist pressures to use alcohol or illicit drugs or to engage in sexual activity. In the absence of information, skills, and a supportive environment, many adolescents can feel alone and isolated, and consequently engage in behaviors that place them at risk of HIV infection and other serious health problems, including STDs, unintended pregnancy, and substance abuse.

[1] For purposes of this survey, illicit drugs included marijuana, hallucinogens, cocaine, or heroin or other opiates, stimulants, barbiturates, or tranquilizers not prescribed by a doctor. Anabolic steroids were not included in the survey.

Why should schools be involved?

No disease in recent history has affected our lives or our schools the way AIDS has. AIDS has forced us to examine our thoughts about some real, controversial, and deeply personal issues such as drug use and sexuality. "The subject of AIDS has plunged the American public into a cauldron of issues, many of which are surrounded by the silence, guilt, and taboos often associated with sexuality, homosexuality, the fear of death, and IV drug use." (Legion, 1990, p. 10)

Yet these issues must be faced. Because schools have access to young people that is unrivaled by any other institution, schools can make the critical difference in preventing the spread of HIV. As John Seffrin, Chair of the Department of Applied Health Science at Indiana University, says, "The school should because the school can and, therefore, the school must." (Seffrin, 1990)

By developing quality education programs that help students reduce their risk of HIV infection, many schools have coped well with the demands of the HIV epidemic. Schools have also responded by maintaining supportive, fair, and humane policies regarding students with HIV infection to protect the rights and health of those affected. In developing these policies and programs, many schools have found new ways to promote students' physical, emotional, and social development.

Why look at classrooms?

Classrooms provide valuable lessons about effective HIV education programs and what promotes learning. Studying school settings offers insight into the kinds of interactions that occur among principal and staff, staff and students, and students and peers. Although success at achieving the ultimate goals of positive health behaviors, improved health, and prevention of new HIV infections might be difficult to observe, classroom observations can provide information about students' acquisition of the knowledge, skills, and behaviors they need to protect themselves from HIV infection and other health-related problems.

RECOMMENDATIONS

The following recommendations are intended to inform state efforts for enhancing students' healthy development and academic performance. They derive from suggestions of administrators, faculty, and students interviewed during site visits, and of project staff. Project staff's recommendations come from their observations during site visits, review of the related literature, and involvement with other CCSSO efforts designed to improve the educational outcomes for every child.

We know from our school visits and related work that state education agencies have been actively engaged for the past several years in a number of initiatives to prevent HIV infection and other health problems. We saw firsthand examples of effective state and local practices, and we have discussed with state and local educators their views about the state education agency's role in promoting school health programs. Therefore, to support and improve school health programs, including HIV prevention, we recommend that state educators use the following strategies:

I. DEMONSTRATE AND ENCOURAGE LEADERSHIP

Most promising programs have the benefit of strong leadership and individual effort to infuse vigor and thoroughness into their programs. SEAs often provide the leverage districts and schools need to initiate quality HIV prevention programs. To provide such leadership, SEAs can

A. Adopt and publicize an official written policy recommending or requiring that HIV prevention programs occur within comprehensive school health programs.

B. Provide the funding or mechanism for funding, materials, time, and technical assistance needed by LEAs to implement such programs.

C. Advocate HIV prevention and comprehensive school health programs in SEA speeches and publications.

D. Highlight promising HIV prevention and school health programs and recognize the individuals responsible for those programs in statewide newsletters.

E. Include SEA health program staff on state task forces to improve and restructure schools and learning.

F. Evaluate, and modify as needed, the SEA's organizational structure to ensure coordination of the health program components. Those components might include health instruction, HIV prevention, substance abuse prevention, health services, physical education, food service, counseling, programs for at-risk youth, and community relations.

G. Help develop and support coalitions to advance comprehensive school health programs.

II. PROVIDE SUPPORT TO ENHANCE CURRICULUM AND INSTRUCTION

Quality instruction and curriculum are essential for the success of any education program. To enhance HIV education programs, SEAs can

A. Provide **curricular** support.

1. Develop a model curriculum or curriculum guidelines for HIV education that LEAs can use or adapt to meet the diverse needs of the children they serve. Such curriculum or curriculum guidelines should be within the context of a comprehensive school health program and should include

   a. Recommended scope and sequence that consider the age and developmental readiness of students and that provide students with HIV education programs before they engage in risk-related behaviors.
   b. Accurate, relevant information about HIV infection and other categorical health problems, including STDs and substance abuse, and reinforcement of those messages in other subject areas.
   c. Activities that teach and allow students to practice using health-enhancing decisions.
   d. Suggestions for integrating HIV prevention and other health topics into the curriculum.

2. Tailor technical assistance to local circumstances and needs. That assistance might include

   a. Advice about adapting curricula.
   b. Review of documents to ensure that the diversity of the local student population is considered and respected.
   c. Critique of locally developed curricula upon request.

3. Encourage LEAs to involve students, parents, business and industry, child-serving agencies, and community leaders in the program planning process and thereby

   a. Build a broad base of support for the curriculum and
   b. Establish linkages that can lead to more effective program delivery.

4. Identify exemplary health education programs and disseminate information about the programs.

5. Provide incentives and opportunities for state and local educators to observe exemplary programs and make informed decisions about how new practices might fit into their schools.

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B. Provide **staff development** support that encourages integral, ongoing programs and that provides coaching when teachers return to their classrooms. To help ensure high-quality staff development programs, SEAs can

   1. Provide technical and financial support for LEA staff development programs designed to promote students' intellectual, physical, social, and emotional development. Such programs should be for all teachers, including those who teach health, and should include

      a. Information about HIV infection, AIDS, and other important health issues and problems.
      b. Explanations of the relationship between health and learning as well as the relationship among health instruction, health and social services, and a supportive, safe learning environment.
      c. Suggestions for accommodating differences in learning styles.
      d. Examples of effective strategies for fostering cooperation between parents and schools.
      e. Strategies for responding to the needs of disadvantaged students.
      f. Explorations of teachers' attitudes and expectations, especially regarding students' ethnicity, gender, economic status, and sexual orientation.
      g. Methods of teaching skill development and controversial subjects.

   2. Help local districts use a variety of approaches for staff development (e.g., stipends for training conducted after school hours or funds to operate districtwide training centers).

   3. Provide on-site training for teachers.

   4. Sponsor training for teams of administrators and staff that foster team building, with periodic follow-up during the school year.

   5. Encourage local districts to collaborate with area health departments on training for teachers involved in HIV education.

   6. Sponsor an annual wellness conference for SEA and LEA staff.

C. Assist LEA staff to **conduct and apply research** related to what constitutes successful instruction, including the impact of diverse backgrounds and learning styles on instructional effectiveness. Examples of what SEAs can do include

   1. Provide schools with summaries of research concerning successful implementation of innovative instructional methods.

2. Provide opportunities for SEA and LEA staff to observe innovative instructional methods.

3. Grant waivers from state requirements to schools implementing promising instructional innovations when those innovations are accompanied by accountability measures. Such waivers might include time for specific subject areas or scope and sequence of instructional topics within a subject.

4. Help LEAs secure resources for innovative programs.

5. Provide incentives, such as grants, technical assistance, or recognition awards, for LEAs and schools that customize programs to meet local needs and evaluate those programs.

III. ASSURE ACCOUNTABILITY FOR LEARNING OUTCOMES

As more communities initiate or improve their HIV education and school health programs, the demand for solid evaluations of the effectiveness of these programs will increase. To assist school districts in evaluating their programs, SEAs can

A. Identify or develop tools for measuring the extent that school health programs foster healthy behaviors. Those tools should measure both

   1. The process of implementation and

   2. Student outcomes in the form of knowledge, attitude, skill, and behavior changes.

B. Provide technical assistance to local educators in the use of evaluation for program improvement.

C. Advise LEAs about ways of working with their communities to address concerns about the collection of evaluation or surveillance[3] data.

D. Include questions about HIV infection and other health topics in statewide testing programs. This not only measures health knowledge but also sends a message to students, schools, educators, and the community that health is an important subject.

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[3] CSSO encourages the use of the Centers for Disease Control's Youth Risk Behavior Survey system to (1) help determine the health status of youth throughout the country and (2) assist educators in planning and implementing effective comprehensive school health programs that include HIV education.

IV. ENCOURAGE ACTIVE INVOLVEMENT OF FAMILIES

In HIV prevention efforts, families model and reinforce positive or negative health behaviors for children. To help districts and schools effectively involve families in health promotion programs, including HIV prevention, SEAs can

A. Identify schools and programs in the state and across the country with high levels of family participation, particularly families who have traditionally had limited involvement with schools, and share the information statewide.

B. Provide staff development training that includes suggestions for planning, implementing, and evaluating family involvement programs.

C. Establish funding and recognition programs for local projects designed to increase family involvement, including those that target special populations of parents, such as teen parents.

V. STRENGTHEN PARTNERSHIPS

The successful delivery of integrated health and social services depends on the ability of educators at all levels to work collaboratively with a broad cross-section of the community, other agency staff, and advocates for the well-being of children. SEAs can foster effective partnerships in the following ways:

A. Model collaboration at the state level by

1. Facilitating collaboration among all SEA staff responsible for health-related issues, and between those staff and the staff working with school improvement and restructuring, Chapter 1, and special education.

2. Working with other state agencies involved with the health of school-aged children, including health and social service agencies, other education organizations, and child and youth advocates to share information and develop collective strategies for strengthening school health education, including HIV prevention programs.

B. Appoint and support a leader within the SEA who has the ability to keep stakeholders focused on common goals and a strong commitment to providing HIV prevention programs within a framework of comprehensive school health.

C. Give staff the time and organizational support to develop intra- and interagency program linkages.

D. Include responsibilities for intra- and interagency work in position descriptions and performance evaluations.

E. Provide staff development training for state and local service providers to help them learn how other youth-serving organizations work and how to collaborate more effectively.

F. Offer technical assistance and incentives to districts and schools that engage in joint ventures that take into account local preferences, needs, and circumstances.

G. Rewrite regulations so they encourage school-based or school-linked service delivery that enhances the safety, health, and civil rights of children and adolescents.

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COMMON ELEMENTS OF PROMISING PROGRAMS

Although no two schools visited by CCSSO designed and implemented their HIV education programs in the same way, the school, district, and SEA staffs we interviewed generally agreed on what programs needed in order to succeed.

For successful implementation, SEA and LEA staff identified community partnerships, sound and far-sighted policies, strong leadership, and adequate funding as necessary elements. For effective programs, these individuals identified effective staff development, sensitive curriculum development, adequate funding, and creative instructional methods as essential. Many indicated a need to involve families in program development, to provide a supportive school environment, to have health and other social services available for students, and to design communitywide intervention programs.

These findings support the calls of education reformers for changes in all aspects of schooling, including the nature and organization of curriculum and instruction, accountability for learning outcomes, policy development, partnerships with families and the community, the school environment, and the availability of health and social services. (CCSSO, 1989)

No school we visited had yet successfully woven all of these different threads into an exemplary program. However, many districts incorporated several of these elements.

How one SEA provided district staff with support and assistance, and district staff worked closely with teachers, other staff, and administrators at each school

The delicate balance between autonomy and support among the state, school district, and school levels is a key ingredient of HIV prevention programs in **Philadelphia, Pennsylvania.** At each level personnel feel appreciated and participate in the decision-making process. Program implementers feel ownership of programs. Monetary incentives and letters of appreciation provide recognition to those who contribute to health programs.

Factors critical for the cooperative effort in Philadelphia include

- A commitment by the state and school district to decentralize the HIV education program to enable educators at the school level to initiate and develop programs best suited for their students. (Although Pennsylvania mandates HIV education, the state does not prescribe a curriculum. Instead, it recommends that districts adopt a curriculum and offers training on how to teach students about HIV and AIDS.)
- A district that keeps the state informed about its activities, policies, and programs.
- A state that respects and encourages reciprocity, using the successes of programs in one LEA, such as Philadelphia, to help other school districts in the state develop programs.
- A district that has a working relationship with the community. For example, one of the district's HIV coordinators matches community-based organizations (CBOs) with schools to meet the needs of students. She informs schools of the services that various CBOs offer rather than pressuring schools to work with specific organizations.
- A district that helps schools secure funding. The district's grants management office prepares all the grants for the school district, especially in regards to finding funds to support school programs.
- A district that has a collegial relationship with its schools. The district HIV coordinators encourage schools to develop innovative approaches to HIV prevention.

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HOW DO LEADERSHIP AND INDIVIDUAL EFFORTS ENHANCE HIV EDUCATION PROGRAMS?

No single approach to HIV education programs ensures success. However, the commitment and leadership of individual educators—exercised in partnership with the community and families—is an essential ingredient of promising HIV education programs.

Leadership requires the participation of individuals with a well-defined vision and the skills to translate that vision into the development of sound HIV prevention programs within their jurisdiction. Such individuals

- make a commitment to students' academic excellence, as well as to their mental and physical well-being.
- form partnerships with other youth-serving organizations in order to strengthen existing programs.
- assess school health programs, including HIV prevention, on a regular basis.
- experiment with new ideas to improve the programs and the delivery of programs to all children and youth.
- focus their energy on developing programs to meet the needs of all children, rather than emphasizing traditional structures and adherence to regulations.

Leadership can come from teachers, school administrators, staff from community organizations and advocacy groups, families, students, and local and state education agency staff. Support of chief state school officers enhances the ability of SEA program specialists to assist local districts in the development and implementation of quality programs.

To provide effective leadership, SEA staff working with health programs, including HIV prevention, must be

- accessible to both district and school personnel.
- willing and able to provide ongoing technical assistance.
- strong advocates for comprehensive health programs.
- able to work with other health education professionals for policy change and desired programmatic outcomes.

Leadership from a chief state school officer

In 1989 the **Florida Department of Education** made a proposal to the Centers for Disease Control, which funds the department's AIDS Project, to assist local school districts that developed innovative AIDS education programs. CDC approved this proposal, and the commissioner of education used her influence to encourage and support creative endeavors at the local level. As a result of this process, a model peer education program for HIV/AIDS was developed and initiated in Sarasota County. Because of the success of this program, it was duplicated in the Northeast Florida Education Consortium and is now expanding throughout the state.

Leadership from an SEA staff person

Florida's director of comprehensive health education and HIV education and a group of superintendents and health educators had success in helping to secure changes in state law. The new law provides that human sexuality education be part of a comprehensive health education program and provides $3 million over a two-year period for implementation. Prior to this legislation, Florida law mandated the separation of sexuality education and health education.

Leadership at the local level

In **Philadelphia, Pennsylvania,** the superintendent encourages staff to try innovative teaching approaches. She participates in special programs and events that raise awareness and funds for HIV prevention; she chaired a walkathon for AIDS that involved students and participated in a day-long seminar that provided parents with information about HIV infection and AIDS. According to the HIV coordinator for Philadelphia, "Without the superintendent's leadership, we could not have gone anywhere."

The HIV coordinator in **Seattle, Washington,** believes that central office personnel should "spend time as teachers in a classroom, if the curriculum they help design or the policy they help draft is to meet the needs of the students." Every year since the inception of the HIV program in Seattle, she has taught at least one HIV prevention class at every grade level. She also teaches a session on teen sexuality each year at school health fairs that deliver HIV prevention messages to middle school youngsters in Seattle. As part of the follow-up to the health fairs, she trains teams of teachers from each middle school. These teams then train the staff of their respective schools to handle questions that might arise due to the health fairs.

Individuals in other agencies can provide specialized expertise and extra resources to strengthen a school's HIV prevention program. For example, a health educator with the **Passaic Department of Human Resources,** Division of Health in **New Jersey** has persuaded the Board of Education in Passaic to support a student health fair and an HIV prevention program. She provides HIV education training in the schools and performs extensive community outreach.

The school principal of **Gardenville Elementary School** in **Baltimore, Maryland,** prepared teachers and parents for the initiation of the HIV prevention program. After attending several district meetings about HIV prevention for elementary students, she invited the district's HIV coordinator to introduce the curriculum to her staff. Then she presented the curriculum at a PTA meeting and gave parents and teachers an opportunity to ask questions about the program. As a result, both teachers and parents became more comfortable with the content of the curriculum.

Individual classroom teachers can also provide the leadership needed for launching and sustaining HIV prevention programs. In **Boston, Massachusetts,** a high school English teacher initiated a peer education program at **East Boston High School.** Originally an after-school activity that focused on drug abuse, the program was so well accepted that peer education became a for-credit course offered during the school day. The program now includes HIV infection and other health issues and has become a nationally recognized model peer education program.

HOW DOES POLICY INFLUENCE HIV EDUCATION PROGRAMS?

Policies are generally of two types. One type addresses students or employees infected with HIV. The other covers HIV prevention programs and often addresses course content, grade levels for implementation, time requirements, and instructors' qualifications.

State and school district policies related to HIV/AIDS infection and prevention provide local school districts and schools with up-to-date information and useful parameters within which to operate. They sometimes provide the impetus schools need to initiate programs by educating the public about HIV, laying a foundation for work, establishing a basis for decisions, and demanding accountability from administrators and staff.

A state policy that led to developing local HIV prevention programs

In **Baltimore, Maryland,** the state mandate "allows us to do what needs to be done," according to one staff member's interview. "The bylaw allows us to talk about condoms; before we could not discuss them [in sixth grade]."

State and district HIV policies can assure students, parents, and staff that their school is a place where issues are dealt with on a safe, proactive, and open basis. An effective HIV policy can create a positive learning and work environment where staff and students feel comfortable, where potential controversies are addressed head on, where people with HIV are supported, and where students can gain the skills necessary to protect themselves from HIV infection.

For state departments of education, HIV policy development presents opportunities to create plans for providing effective instruction, including the what, when, where, how, and by whom of the program. Such a process often forces state leaders to think about the context for instruction, the appropriate content for specific grade levels, and whether the policy will be a mandate or a recommendation.

Development of an HIV policy can accomplish the following:

- A systematic review of how to create the capacity for delivering effective HIV prevention programs.
- The involvement early in the process of community and school-based groups and individuals whose support the school needs for an effective program.
- The creation of a plan of action that outlines program objectives, steps to take, a timetable, resources needed, and resources available. (NASBE, 1989)

Informed school policies can also teach respect and compassion for those who are HIV infected. For instance, the Massachusetts Board of Education's HIV Policy

Guidelines state, "Students with AIDS HIV infection have the same right to attend classes or participate in school programs and activities as any other student." (Massachusetts Board of Education, 1991) Such a policy could positively influence students' attitudes toward people infected with HIV.

Policy development in response to a significant event

The **Sarasota, Florida,** school district acted quickly to adopt an HIV education program when a family with two brothers infected with HIV moved into the district after being burned out of their home in another county in 1985. The Sarasota school district admitted the boys and developed a policy to provide HIV instruction to all students. As a result of this nationally publicized case and the proactive stance taken by district staff in developing a policy, the HIV prevention program in the Sarasota school district was implemented successfully with little resistance from parents or the community.

The **Pittsburgh, Pennsylvania,** school district responded to a rumor that a teacher in a western Pennsylvania school had AIDS. At the urging of the school board president, the district superintendent and the director of the county health department appointed a task force. The task force, made up of school administrators, teachers, parents, public health officials, and other representatives of the community, was charged with putting a policy in place so as to prevent disruption of school activities. Within two months, the task force proposed a policy and the board adopted it. In 1985 Pittsburgh thus became one of the first school districts in Pennsylvania to have a policy that addressed HIV education, as well as the rights of students and employees who were infected with HIV.

In 1987, when the Pittsburgh school district learned of a student who had AIDS, its policy was already in place and the affected student continued attending school. The school notified the public and press in order to deflect any charges that the school district concealed information, but the student remained anonymous in accordance with the policy. The school district prepared for a public outcry, but received only 40 queries in the days following the press conference. Public opinion was reflected in the following letter that appeared in the January 6, 1988, edition of the *Pittsburgh Post-Gazette*:

GOOD AIDS POLICY

> I am a student in a Pittsburgh public school and I would just like to say I am very pleased with the school board's decision that the student with AIDS will be able to continue his education. I know a few people who think that it is wrong, but I cannot see their point of view. Studies have shown that AIDS can only be passed through blood or sexual transmission. I also feel that it was very inconsiderate of the school board to tell the public about the student.

WHAT DO EDUCATORS CONSIDER ESSENTIAL FOR AN EFFECTIVE HIV CURRICULUM?

The educators we interviewed identified the following as components of effective HIV curricula:

- Current information and accurate facts about HIV and AIDS.
- Identification of behaviors that put people at risk for infection.
- Activities that help students develop skills they can use to make life-enhancing decisions.
- Content that is consistent with community values and beliefs.
- Integration into a comprehensive school health program.
- Materials and strategies that take into account students' cultural and sexual differences.
- Enlistment of students, parents, community leaders, and staff of other youth-serving organizations in the curriculum planning process.

Involvement of a broad cross-section in developing a curriculum

When Maryland enacted a bylaw mandating HIV education, the **Baltimore, Maryland,** school district decided to revise its HIV curriculum. The district hired health teachers to rewrite the curriculum based on changes suggested by teachers and an analysis of student surveys. A committee that included specialists from the state department of education, colleges and universities, the American Red Cross, Planned Parenthood, the state health department, and a local hospital reviewed the draft revision. The resulting curriculum goes beyond the state mandate.

State and local collaboration to develop a curriculum

In Passaic, New Jersey, the district's Department of Curriculum and the **New Jersey Department of Education** jointly developed a curriculum guide for grades 6–12. Although the guide suggested ways to integrate HIV prevention messages, it encouraged teachers "to adapt the material to the ability levels of their students and to create a 'safe' environment in which students can discuss the topic freely and to communicate with students, with ease, sensitivity, and tact in an objective unbiased manner."

The **Washington Department of Education** assisted school districts by awarding grants of ten thousand dollars to school districts for curriculum development. The state also provided those districts with technical assistance, if needed.

HOW ARE SCHOOLS PROVIDING QUALITY HIV INSTRUCTION?

As part of a variety of subjects

In the elementary school we visited, classroom teachers provided HIV instruction. In most middle and high schools, students learned about HIV in a health education course taught by a health, physical education, or science teacher. However, we also observed HIV education taught as part of other subject areas, such as history and English.

Integration of HIV prevention into various school subjects

Regular classroom teachers provide HIV instruction at the **Raphael Cordero Bilingual Junior High School** in **New York City**. Because the school has no certified health teachers, all teachers receive basic training about HIV infection and about cultural values of the school's population concerning death and dying, sex, and drugs. Although all teachers receive training, three teachers have primary responsibility for implementing the HIV prevention program.

English and history teachers deliver HIV instruction at the high school level in the **New Haven, Connecticut,** school district. Teachers attended four hours of training one month prior to implementing an HIV prevention program. According to the teachers interviewed, their training was well-matched with a curriculum that included inviting people infected with HIV and medical students to assist with the program.

As part of a comprehensive school health program

Ideally, HIV prevention education should be part of a comprehensive school health program. A comprehensive school health program is an organized set of policies, procedures, and activities designed to protect and promote the health and well-being of students and staff. It includes health services, a healthful school environment, and health education, as well as guidance and counseling, physical education, food service, social work, psychological services, and employee health promotion. (Joint Committee on Health Education Terminology, 1991)

Implementation of a comprehensive school health program

Believing that a program coordinating comprehensive school health education and human services would have a greater impact on student health and behavior than existing prevention and intervention efforts, **Massachusetts** awarded grants to several districts for the initiation of comprehensive health programs. All the selected school districts used their grants to develop coordinated programs comprising health instruction, school counseling services, school health services, and outside agencies. The state plans to assess Boston's project and use the results to guide the direction of health programs statewide.

By selecting competent teachers and providing training

According to the teachers we interviewed, the competencies required of teachers responsible for HIV instruction include

- A background in health education, including knowledge and skills for influencing student health behaviors.
- The ability to create a comfortable environment in which students can discuss issues with ease and without fear of ridicule or censorship.
- Comfort with the subject matter and dealing with affective issues.
- A willingness to address students' attitudes and behaviors in addition to factual information as a means of facilitating an examination of their lives and the choices they make—especially in relation to potentially destructive behaviors. (EDC, 1990)
- Knowledge of the community and the resources available for follow-up information about school and community services.
- Realization that students come to school with different attitudes, beliefs, and levels of knowledge.

Training that enhances teachers' comfort with HIV-related issues

The **Seattle, Washington,** school district uses health fairs to provide information about HIV to middle school youth. Prior to the fair, the district HIV coordinator trains teams from each middle school to provide follow-through after the fair is over. These teams train their school staff to handle questions or situations that might arise as a result of the fair. This type of training is essential because students make disclosures in class and privately as a result of the fair. Furthermore, school teams and outside facilitators who participate in the health fairs are available on an ongoing basis to assist school staff when HIV-related issues arise.

Health teacher provides information that challenges misconceptions

A health teacher at **Forestville High School** in **Prince George's County, Maryland,** wanted to ensure that all of her students realized the seriousness of HIV infection but noticed that, "Many of the black males in my class said they didn't need to know about HIV because it was a gay disease—and that there are no black gay men." To dispel this myth, the health teacher shared with the class Maryland's statistics on the number of AIDS cases broken down according to gender, race, and number of cases according to each transmission category.

A teacher uses pretests to determine content

A health teacher at **Schenley High School** in **Pittsburgh, Pennsylvania,** modifies the way she delivers HIV prevention messages depending on her students' level of knowledge and their attitudes about the subject. With each class, she uses a pretest to "know where the kids are coming from." Currently, she spends two or three days presenting information about HIV—less than when she began teaching about the subject—because "the kids are getting more knowledgeable and more comfortable each year."

Sensitivity training for teachers

Teachers in **San Diego, California,** received sensitivity training sponsored by the school district. During these workshops teachers learned about HIV as well as how to discuss sensitive issues, such as death and dying, with students.

In **Boston, Massachusetts,** only teachers who self-selected provided HIV instruction. The district, in cooperation with the Boston Department of Health and Hospitals, provided training for those who elected to teach about HIV-related issues. The training content depended on teachers' familiarity with HIV and its related issues and on their experience providing HIV instruction.

Frank discussions in one school

In **Passaic, New Jersey,** we observed an eighth grade class led by a staff person from the local Department of Human Resources, Division of Health who answered students' written questions about HIV. During the discussion, students were very frank and freely expressed their biases. Students' concerns included issues related to condom use and the types of sexual acts that present the greatest risk of HIV infection. The visitor responded to questions and comments candidly while skillfully incorporating facts about HIV into the discussion. This straightforward approach using the same language as the students effectively provided accurate information about HIV. Although this direct, sometimes explicit, approach was appropriate for this class, it might not be appropriate in another setting.

In virtually every school we visited, teachers emphasized the need for staff development at the district and school levels. Staff development programs related to HIV education varied and included ideas on how to create a trusting and comfortable environment, guide student discussion, and handle name-calling and use of negative language; suggestions for responding to difficult student questions; insights on providing appropriate, culturally relevant messages that empower students to make healthy decisions; and ways that teachers can determine and use suitable resources to augment HIV lessons.

Staff development should include ongoing support as well as formal training programs. Effective teacher training programs help teachers understand their own feelings, values, and attitudes.

A summer institute for staff development

The **Florida Department of Education** sponsors a week-long summer institute that offers health education training and recertification. Teachers who enroll in the summer institute receive their regular salary while they attend. University students may also participate and receive college credit. The summer institute includes 10 instructional units, including HIV prevention education, drug education, and comprehensive health education.

Ongoing support for teachers

In **San Diego, California,** teachers from the district's Social Concerns Program provide continual support and training to teachers who implement HIV lessons. Social Concerns teachers consist of highly trained health educators working in teams (male and female), with each team assigned to three to five schools on a permanent basis. They provide drug and family life education at the secondary level and drug education at the elementary level. In conjunction with district HIV coordinators, these teachers also develop approaches for other teachers and health professionals to use in improving the content and delivery of school HIV prevention programs, and they help teachers develop the confidence and comfort they need to incorporate sensitive health topics into other courses.

By using a variety of strategies in HIV prevention programs

Students come to school with diverse experiences, languages, learning styles, and levels of maturity. To create an environment where all students can become active, engaged learners, where they learn to think critically, to make positive choices about their health, and to avoid or reduce high-risk behaviors that can lead to HIV infection, teachers must help students connect what they learn in school to the world in which they live. Effective HIV prevention programs are developmentally appropriate and culturally relevant; they meet students "where they are, rather than where the AIDS educator would like them to be." (Tafoya and Wirth, 1991, p. 92)

The HIV prevention programs we observed encompassed a variety of teaching strategies: lecture, class discussion, brainstorming, worksheets, debate, individual and group research, interviews, films, filmstrips and videos, oral presentations, question boxes, role playing, creative writing, peer education, involving a person with AIDS, special performances, and visual displays. The following sections describe

some strategies identified by the educators and students we interviewed as the most promising for effectively educating children and youth about HIV infection and AIDS.

Including peer educators. When youth talk about a health risk—whether it is HIV infection, substance abuse, or teen pregnancy—other youth are apt to listen.

Peer educator training in various settings

Generally teachers select candidates for **Boston, Massachusetts' East Boston High School's** peer education program based on students' leadership potential, though some are self-selected. The group reflects the racial and ethnic diversity of the student population. Enrollment in the peer counseling program is contingent upon signing a statement promising not to abuse drugs or alcohol during the school year. The Medical Foundation Prevention Center, a community-based organization (CBO), trains students in peer counseling techniques, including skills that will enable the counselors to make good health decisions for themselves. Students attend classes at the prevention center twice a week throughout the school year. The curriculum addresses the role of peer educators, building self-esteem, decision making, values, effective listening, and public speaking. Students receive grades based on their participation in class and their handling of projects assigned by the prevention center and their teacher. Peer counselors meet and talk with students informally during unstructured moments, make formal presentations at conferences and on radio talk shows, and give talks on HIV and HIV-related topics in the schools. They also provide education and training to young people at emergency shelters for runaway adolescents. Students and teachers credit the supportive nature of peers helping other peers for the program's success.

In **Seattle, Washington,** the peer education program is community-based. Ten Seattle area community agencies formed the Coalition for AIDS Peer Education (CAPE) to create and support AIDS peer education projects for adolescents. CAPE serves both in-school and out-of-school youth; white youth and youth of color; and gay, lesbian, and heterosexual youth. CAPE empowers students through adult-guided activities that provide information and skills-based training to peer educators. In turn, the peer educators inform other Seattle youth about HIV and other health issues. CAPE programs are initiated by students, and students determine what activities they will undertake. In some schools, CAPE representatives met with teachers and administrators, who then informed students of the opportunity to become involved. In other schools, students founded chapters on their own initiative.

CAPE conducts a two-day fall retreat for all new peer educators. Experienced peer educators train the recruits. At the retreat, students meet peer educators from other areas of the city, learn about HIV infection and AIDS, plan activities for their school's CAPE project, and receive training on how to be effective peer educators. CAPE programs include school assemblies on HIV infection and AIDS that involve presentations by people living with AIDS (PLWAs); designing, producing, and distributing posters with HIV and safer sex messages in the schools and community; making Christmas baskets for PLWAs in local hospitals; distributing pencils inscribed with HIV prevention slogans; making HIV education presentations at middle schools; and receiving Red Cross training to care for hospice AIDS patients. CAPE site representatives provide ongoing monitoring and support to maintain each local project.

Involving people living with HIV infection and AIDS[4] (PLWAs). According to students we interviewed, listening to a PLWA was an influential factor in getting

[4] National Association of People with AIDS prefers the terms "People With AIDS" (PWAs) and "People Living With AIDS" (PLWAs) rather than "AIDS patients" or "victims," which imply that people are overwhelmed and unable to cope with their situation. According to the Association, the terms PWAs and PLWAs may be used to describe both those who are HIV positive and those with AIDS.

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them to change risky behaviors. Students reported that PLWAs encouraged them to communicate openly about their feelings and fears about HIV. Teachers regarded PLWAs as credible sources of accurate information who verified and clarified what students had already heard.

Personalizing HIV infection helps students deal with fears and misconceptions. (CPO, 1989) PLWAs who are able to communicate the reality of living with HIV infection can sometimes penetrate the denial of mortality among young people. PLWAs personalize the HIV epidemic and give advice on how to avoid infection in a manner that generates compassion and greater understanding rather than fear.

As with peer education programs, including PLWAs is usually part of a more extensive HIV prevention program. Most programs that include PLWAs as guest speakers also provide lessons on HIV before the speakers come.

The WEDGE Model for involving PLWAs

Boston, Massachusetts, and **New Haven, Connecticut,** school districts patterned their use of PLWAs after the WEDGE HIV Education Program developed by the Department of Health in San Francisco.

The goal of the WEDGE HIV Education Program is to stop the spread of HIV infection among adolescents by

1. Disseminating information about AIDS, the HIV virus, and its transmission.
2. Reducing fear and misinformation about AIDS.
3. Educating youth about how to reduce risk.
4. Helping teenagers choose to delay the initiation of sexual intercourse.
5. Discouraging experimentation with drugs, preventing intravenous (IV) drug use, and eliminating the practice of sharing needles.

WEDGE integrates factual information with personal accounts of HIV infection. It requires four presentations: basic facts and concepts about HIV, discussions, exercises, and personal histories shared by trained speakers. Frank dialogue and interaction with a PLWA promote students' awareness of personal risk for HIV infection. An underlying premise of the WEDGE program is that increased awareness stimulates active and positive preventive behaviors.

Student response to the PLWAs has been strong and positive: "The best program this year . . . very informative, very real, very professional speakers." "Sara [a woman with AIDS] made it seem very real. . . . I thought, this woman isn't much older than I am, and she was a virgin and got AIDS from this one guy she slept with. You bet I'm going to think about AIDS." "I don't want to see another video about AIDS. The same old thing isn't going to get kids to change the way they behave. This year though, I think people stopped and thought, 'Wow, that could really happen to me.'"

Teachers' reactions were also positive: "Most kids' reaction is that this is really sad that it happens to people, but it's also scary that it could really happen to me."

Sidney, a PLWA with the Boston schools, has an engaging speaking style and a dynamic personality that enhance his ability to reach the students. Before beginning a presentation he likes "to get a sense of where the kids are . . . assess their current knowledge base so I can tell them what they need to know about AIDS. I go from the 'abstract' to the 'real' [and] bring the message to a level where the kids can personalize the disease. I tell kids how it feels to have AIDS-related pneumonia, how my family reacted to me when they learned I had AIDS, how I deal with dying, and how I dealt with my anger and denial of the disease." Sidney stresses that every choice a student makes has consequences, either positive or negative. All of Sidney's HIV lessons include basic knowledge about HIV, the personal experience of having AIDS, and the opportunity to ask questions.

Using special performances and visual displays. Special performances such as theater, skits, and raps are thought-provoking and entertaining ways of involving students in delivering information. Skits can provide a springboard for discussing students' feelings and attitudes. Raps can be a powerful educational tool, especially for youth who love to write and perform. (CPO, 1990) Visual displays such as posters can deliver HIV prevention messages.

Using diverse media to present HIV prevention messages

The **Charlotte-Mecklenburg County, North Carolina,** school district used both skits and rap music to deliver HIV instruction. FOCUS, a group of students organized by Planned Parenthood, uses plays, skits, and rap music to address adolescent issues such as teenage pregnancy and suicide. In conjunction with school health staff, FOCUS designed a presentation intended to address adolescents' attitude of invulnerability to HIV infection. School nurses provided performers with accurate information about HIV. FOCUS gave a performance for parents before presenting it to students.

After its football team won the division championship, **Benjamin Franklin High School** in **Philadelphia, Pennsylvania,** received an HIV minigrant from the district to purchase jackets for the players. The jackets carried the school insignia on one sleeve and an HIV prevention message on the other. All of the football players received special training about HIV to prepare them to respond accurately when asked about HIV/AIDS. In addition, student-designed posters with messages about HIV and AIDS are displayed throughout the school.

Many of the schools CCSSO visited had visual displays on the walls of health classrooms. In **Greenway Middle School** in **Pittsburgh, Pennsylvania,** the teacher displayed brightly colored health posters and homemade signs urging students to make healthy choices. In a bright, cheery classroom at **Forestville High School** in **Prince George's County, Maryland,** posters about making responsible decisions regarding AIDS, drugs, sex, smoking, and nutrition reinforce positive health messages.

HOW DO STATES AND DISTRICTS EVALUATE HIV EDUCATION PROGRAMS?

Program evaluation helps assess the effects of HIV programs, increase their effectiveness, determine if resources are being spent as intended, identify factors that promote or limit success, and inform future funding decisions. (U.S. Conference of Mayors, 1990)

Traditionally, acquisition of knowledge has been the hallmark of effectiveness and success in most educational programs. Since the ultimate goal of school-based HIV education programs is reduced numbers of youth placing themselves at risk for HIV infection, evaluation of such programs requires more than testing student knowledge. Increasing knowledge about HIV and AIDS is only one part of an overall effort to influence and reinforce behaviors that will eliminate or reduce students' risk of HIV infection. All the programs we observed, however, were evaluated solely on knowledge outcomes; none were evaluated on the basis of behavioral or attitudinal criteria.

Both state and local education agencies evaluate to some degree their HIV education programs. Most of the sites we visited assessed their HIV programs by using surveys requesting descriptive information about the program and by collecting data from students' tests of knowledge about HIV and AIDS. Monitoring and assessment were rarely performed on a site-visit basis. To a great extent, the sites we visited rely upon the technical assistance begun in 1988 by the Centers for Disease Control to help in the assessment process.

In some districts the responsibility for monitoring programs is given to a school-level employee—a principal, assistant principal, or teacher—who provides the district office with information for improving program delivery. In districts with health coordinators, these staff often monitor HIV programs in the schools. Those coordinators who are able to keep in close contact with schools get a good sense of how the programs are operating and can therefore make suggestions to strengthen and better coordinate the entire health education program.

Since 1988 CDC has directly funded 16 school districts in cities with the highest number of reported AIDS cases to set up HIV education programs. These districts have increased their evaluation capacity.

Despite dedicated and knowledgeable staff, many of the districts we visited were doing very little to evaluate their HIV education programs. Reasons cited included

Lack of resources. In many states a combination of budget cuts and the lack of a comprehensive health education requirement has meant minimal funding for health education.

Insufficient staff time. At a number of sites, staff were not allotted the time necessary to conduct program evaluation.

- **Controversy over evaluation tools.** Many of the district and state staff interviewed believed that HIV programs could be more easily monitored if the information covered in health units was included on state assessments or tests required for graduation.
- **Lack of expertise.** Many of the staff members expressed a need for technical assistance regarding program evaluation.

Many educators with whom we spoke expressed a need for evaluation of student behavioral changes as a result of HIV education and wanted help from SEAs and LEAs to develop more creative, outcome-based methods of evaluation.

States and districts monitor HIV programs

Although the **Pennsylvania Department of Education** monitors HIV education programs during regular Chapter 5 visits to schools, only a small number of programs (40) can be covered each year. To augment this process, the Department invites school districts to submit instructional materials they develop to the SEA for a voluntary review, since local school districts in Pennsylvania develop their own HIV education materials. (CCSSO and NASBE, 1991) The SEA is also developing a statewide health education test that will include questions about HIV and AIDS.

The **Philadelphia, Pennsylvania,** school district has encouraged schools to implement HIV education by awarding minigrants. District staff use the application and follow-up reporting process as one way to monitor HIV programs.

In **Dade County, Florida,** the school district's Office of Program Evaluation has been monitoring and evaluating the HIV program since 1987. District staff monitor curriculum utilization, number of teachers providing HIV education, and number of school and community personnel trained. They also collect data as part of a Curriculum Impact Study, which determines the extent to which HIV education is provided in the schools, the extent to which the district's curriculum guidelines are used, whether program activities are coordinated, and the extent to which program goals and deadlines are met. The county uses information from these surveys to improve the overall effectiveness of HIV programs.

As part of their CDC grant, the **Baltimore, Maryland,** school district evaluated the effectiveness and impact on student outcomes of its HIV curriculum at the secondary level. Using those data, health teachers redesigned the health curriculum.

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WHY MUST SCHOOLS INVOLVE FAMILIES IN HIV EDUCATION PROGRAMS?

The family is a child's first teacher. It sets the stage for a child's success in school and determines a child's values and worldview. When schools work in partnership with children's first educators, schools, families, and students all benefit. Family involvement increases the likelihood that children will achieve academically in school. Knowing their contributions are valued, families may become more actively involved in various aspects of their children's education. Schools profit by getting help and support from families.

Family involvement in education takes different forms. Traditionally, schools have asked families to support their efforts by attending open-house nights, participating in parent-teacher conferences, monitoring homework, and reinforcing school discipline policies. Today, educators are emphasizing broader ways to work with families as partners in education.

Family involvement enhances school-based HIV prevention efforts by

- providing family members the opportunity to learn about HIV themselves.
- assuring that the content of the HIV education program is not in conflict with community beliefs and values.
- enhancing respect between teachers and family members.
- providing students with consistent role models for positive health behaviors both at home and at school.
- reinforcing the HIV and health information learned in school.

Examples of family involvement include

- reviewing the school's curriculum.
- providing input to help shape the program.
- observing HIV and health education sessions.
- participating in homework assignments designed to encourage family communications about HIV.
- working with teachers to bring about desired health outcomes for children.

One obstacle to increased family involvement identified by school staff is convincing families that they indeed have an important role to play in the school's HIV education program. Schools should provide an atmosphere where families feel welcome, appreciated, and a part of the school's mission. Family involvement should be part of the ongoing effort of the school and be reflected in the daily attitudes and actions of school staff. When families are valued as partners in the educational endeavor, schools can be more effective in securing family support.

Although all the schools we visited acknowledged the importance of family involvement, few successfully provided opportunities for such involvement. However, the examples of schools that have established valuable relationships with families stand as proof that difficulty in finding ways to include families should not stop schools from seeking their valuable support and involvement.

Schools that involved families

The **Philadelphia, Pennsylvania,** school district sponsored an HIV education day and invited all parents in the district to attend. Community-based and tenant organizations helped recruit parents. To encourage participation, the district held the event on a Saturday, used school buses for transportation, provided child care, served lunch, translated information into several languages, and used culturally sensitive materials. Topics included basic HIV information, how to communicate with children about HIV, and the parent's role in HIV education. In addition, resource materials were available. More than 500 parents attended. The district attributes its success to extensive planning, respect for cultural differences among the participants, and the special logistical arrangements that made it easier for families to participate.

In **Prince George's County, Maryland, Forestville High School** increased its family outreach capacity in the 1989–90 school year by adding a full-time social worker to a staff that already included a part-time nurse and three counselors. This counseling team provides "emergency response" to students and families in crisis, linking them with social services in the community. This example of parent involvement shows a willingness on the part of the school to reach out to families and offer needed assistance, which fits well with the principal's view that the school can best help students by supporting families.

In **Baltimore, Maryland, Gardenville Elementary School's** rapport with parents made it possible to develop an HIV program that is acceptable to the community. The program, which was nearing startup at the time of our visit, is designed for grades three and four, with information on the HIV-related issue of intravenous drug abuse starting in kindergarten. Gardenville Elementary School has an actively involved parent committee, with parents volunteering during the day to assist teachers in the classroom. This positive relationship between school and parents made it possible to tackle the difficult task of presenting such sensitive issues to young children.

Before a school may implement an HIV program, North Carolina requires the school to conduct a parents' awareness night. During this meeting parents learn about HIV infection and AIDS; preview the methods, materials, and objectives to be used; and discuss ways of reinforcing the students' education at home. Parents sign permission forms for their children to participate in the sexuality and family living unit in which HIV education is provided. At **McClintock Junior High School** in **Charlotte, North Carolina,** no parents requested having their children excluded from this unit.

HOW DO SCHOOLS USE PARTNERSHIPS WITH THE COMMUNITY TO ENHANCE SCHOOL-BASED HIV EDUCATION EFFORTS?

School-based education about HIV and AIDS raises a number of controversial and potentially divisive issues, including instructing students about early sexual activity, alcohol and other drug use, and homosexuality. The participation of a broad cross-section of the community has proven to be very productive in developing and maintaining effective HIV education programs—programs that reflect community standards.

Schools alone cannot address all the underlying causes of behaviors that put youth at risk for HIV infection, nor is it their responsibility to do so. It has become increasingly evident that responding to a problem as complex as preventing HIV infection requires a community effort. The most effective programs involve communitywide, multi-agency approaches to provide needed services. As Don Iverson of the University of Colorado Health Sciences Center explains, educating youth about HIV infection requires a "multilevel risk approach" that encompasses the community, school, and family, as well as the individual. (Iverson, 1991)

Cooperative efforts among organizations, agencies, and special interests can bring to light the views, concerns, and controversies likely to surface during policy development and program implementation. By addressing such issues, schools are less likely to be derailed or stalled by unforeseen attacks or a lack of support. Group members can provide their own expertise related to program development, build community support, and circumvent controversy. In many cases, task forces and advisory boards continue to meet and provide ongoing leadership and support for school-based HIV education programs.

Schools use cooperative efforts to build a broad base of support for HIV education

When the **Pittsburgh, Pennsylvania,** school district needed to get an HIV policy in place quickly, the superintendent of schools and director of the Allegheny County Health Department appointed a task force of school administrators, teachers, parents, public health officials, and others to propose a comprehensive policy on HIV and AIDS. Using recommendations from the health department, the task force completed its mission within two months. School officials called the contribution of the Allegheny County Health Department invaluable, because that agency had credibility with task force members. The endorsement of groups with broad and varied perspectives created community acceptance of the final product.

In the **Dade County, Florida,** school district the district HIV coordinator used a task force of district staff and community-based organizations (CBOs) to develop an HIV education program that was multicultural and multilingual. The CBO staff met with the HIV coordinator to discuss the school system's guidelines for HIV education and the specific tasks each CBO might undertake. Instead of contracting CBOs to render specific services, the district collaborated with them to provide reciprocal assistance and to share resources—a process that maximized flexibility and responsiveness.

Many of the school districts we visited assembled a task force or advisory group when first conceptualizing HIV policies and programs. Members of these groups included representatives of some or all of the following:

- advocacy groups.
- clergy.
- parents and parent organizations.
- students.
- health department officials.
- state or local health education specialists.
- school employees.
- nurses.
- physicians.
- teachers' and administrators' organizations.
- community outreach workers.
- social services personnel.

In addition to reaching out to the community for help in program development, schools also benefit by building partnerships with the community to help maintain support and strengthen a school's capacity for program delivery. Close coordination with the community supports the efforts of the school through reinforcement of lessons learned in school. In order for the HIV prevention message to be translated into behaviors that reduce the risk of HIV infection, students need to hear the same message at home and from other sources that they hear at school. And because schools cannot handle all the problems that today's youngsters bring with them to school, cooperative efforts with the community are necessary to augment the school's capacity to address the different factors that put youth at risk for HIV infection.

Schools also work with health departments, community-based organizations, and other private and public agencies to deliver HIV education programs. In cases where more than one organization provides assistance, the school district usually works with individual schools to coordinate these cooperative efforts.

An advisory committee provides ongoing support

In **Sarasota, Florida,** the Health Advisory Committee, which includes representatives from 31 school sites and from the community, helps the district plan its school health education program, including an HIV education component. This group recommends what health education programs and services schools should offer and identifies funding priorities. The Health Advisory Committee prioritized student health needs and recommended an effective health education program with a strong HIV education component. At the time of our visit, the committee was working to revise health services delivery to students.

School districts that formed community partnerships to strengthen program delivery

A health educator from the Division of Health in the **Passaic, New Jersey, Department of Human Resources** convinced the Passaic Board of Education to sponsor a health fair for students. One topic covered at the first fair was HIV infection and AIDS. The health fair has now become an annual event in which local hospitals and health educators participate.

The Division of Health and several local agencies and CBOs, through a grant from the New Jersey Health Department, formed a consortium of youth-serving agencies and groups representing various ethnic and racial populations to provide HIV education. The division sends a health educator into classrooms and conducts outreach activities in the community.

The Division of Health has significantly supplemented the resources of the Passaic School District. Staff from the Division have developed lesson plans for the second through sixth grades, sponsored a puppet show, and created a coloring book to help the younger children understand the nature of HIV and AIDS and why they do not need to be afraid of people with AIDS. In addition, Division of Health staff evaluate the effectiveness of the programs they sponsor in the schools.

Sarasota AIDS Support (SAS) is a nonprofit community-based organization that coordinates and delivers services and support to persons with HIV infection or AIDS and also to their partners, family, and friends. It also promotes prevention education and training; encourages education and behavior modification among persons involved in high-risk activities; assesses needs for present and future services; provides crisis management and outreach services; and serves as the lead agency in strategic planning and advocacy in the community.

SAS has assisted the school district by making presentations in area high schools during the district's AIDS Awareness Week and by cosponsoring with the health department a play about HIV prevention that is presented in local high schools. SAS, the first local agency to have a 24-hour hotline service, was working with the school district at the time of our visit to establish a local AIDS hotline specifically for teens.

HOW DOES THE PROVISION OF HEALTH AND OTHER SUPPORT SERVICES STRENGTHEN HIV EDUCATION EFFORTS?

In working toward the goal of helping students develop the skills they need to protect themselves from HIV infection and make life-enhancing rather than life-threatening decisions, special attention should be paid to health and other support services. A school that has the ability to provide or coordinate the provision of health and other services reinforces the message that a student's physical, emotional, and social well-being are important. Why should students who do not receive proper health care believe that protecting their health is important? What incentives do students living in dangerous, depressing circumstances have to avoid risky behaviors?

Aside from reinforcing classroom HIV and health instruction, the availability of health and other services is a crucial determinant of an HIV education program's ability to address circumstances that put students at risk for acquiring HIV. Schools with the capacity to help students cope with these circumstances are in a better position to deal with a whole host of problems, including drug abuse, early childbearing, school failure, and delinquency, as well as HIV infection and other sexually transmitted diseases. To combat these problems, students need a comprehensive support system that not only responds to crises but encourages healthy development as well.

HIV-related services that schools can provide to students include the following:

- access to school- and community-based physical and mental health services,
- counseling concerning adolescent development, human sexuality, identity formation, peer pressure, and death and dying,
- taking the lead in coordinating all available support services,
- referring students to other agencies. (AACD et al., 1990)

Schools with comprehensive health services

A school-based health clinic at **Benjamin Franklin High School** in **Philadelphia, Pennsylvania,** provides information about HIV infection and AIDS as well as physical examinations, including vision and hearing screening and some laboratory tests. A joint effort between the school and the clinic to prevent adolescent pregnancy helped reduce the number of teen pregnancies from 90 to 59 over the course of one year.

In October 1989 **Jordan High School** in **Los Angeles, California,** opened a comprehensive school health center with funds from the Robert Wood Johnson Foundation. The Watts Health Foundation provides health services. The clinic, open from 8:00 a.m. to 5:00 p.m., provides no-cost basic health care—including physicals, immunizations, and contraceptives—for students and their dependents. If a student is covered by health insurance or eligible for Medicaid, the clinic seeks reimbursement from these sources. The clinic does not provide referrals for abortion services nor is abortion counseling available. Parents must provide written consent for students to use clinic services.

The privately funded health clinic is colocated with the school health office, which allows for close coordination between school and clinic activities. For instance, the health clinic has an extensive drug prevention program and provides individual counseling for students and instruction in the school's health courses about drugs. Health clinic staff also work with other classes at the request of teachers.

At the time of our visit, Jordan High School was one of three sites chosen to have school-based health centers by the Los Angeles Board of Education based on high rates of teen illnesses, school dropouts, and pregnancies. The principal felt the board acted courageously in refusing to be swayed by opponents of the clinics.

Schools with special services

In **San Diego, California,** HIV education is part of the Social Concerns program, which includes two separate teaching units dealing with substance abuse and responsible sexual behavior. The program is structured to increase students' knowledge and build their capacity to understand their emotions. In addition to providing information about such subjects as human reproduction and abuse of alcohol and other drugs, the curriculum deals with self-respect, acceptance of self and others, moral and ethical behavior, responsible interpersonal relationships, and positive attitudes toward love. All Social Concerns teachers are also counselors and are available for group and individual counseling. They also act as resources to other teachers, school administrators, and support staff such as the school nurse.

The **New Haven, Connecticut,** school district receives funding from the Joseph P. Kennedy Foundation for its Community of Caring program. This program provides enhanced services to pregnant and parenting teens, a group of students who are at high risk for HIV infection. HIV education is a component of this comprehensive program, which helps teens develop life skills that assist them in making healthful, constructive decisions about their futures.

Students in this program attend an alternative high school where they take regular coursework while receiving additional instruction and counseling. They learn about child care, sexually transmitted diseases, contraceptives, and HIV infection and AIDS. After the birth of their babies, students return to their regular high school and participate in a course for teenage mothers. Teachers of this course act as advocates for the new mothers and also work with teen fathers in an informal setting. Fathers receive information on responsible parenting, HIV prevention, and other important health issues.

WHAT IS THE ROLE OF THE SCHOOL ENVIRONMENT IN HIV EDUCATION PROGRAMS?

School environment—the physical, psychological, social, emotional, and organizational culture of a school—can enhance students' acquisition of knowledge, understanding of ideas and issues, application of learned concepts in day-to-day activities, and practice of life-enhancing behaviors. Academic achievement and well-being flourish in an environment where administrators and staff have high expectations for all students, where they promote close school-parent-community relationships, where administrators include staff in the school decision-making process, and where teachers actively involve students in the learning process.

When schools view themselves as a community, implement schoolwide plans for academic improvement, increase family participation, and involve students in community and social activities, risks for adolescent health problems decline. (Hawkins and Catalano, 1990) Schools that foster positive school norms are likely to implement other components of effective HIV education programs, such as community and family involvement and diverse teaching strategies, including cooperative learning and peer education.

Often the same factors that contribute to a healthy school environment and an effective HIV education program are components of schoolwide restructuring efforts. School restructuring can be briefly defined as the fundamental redesign of the organization and methods of schooling and has become a major focus of discussion about education in the United States. (CCSSO, 1990) More and more, educators and other professionals concerned with the education and health of children are recognizing that traditional schooling does not adequately service an increasingly large proportion of students and that traditional health education programs do not meet their complex health needs. School restructuring changes the ways that schools are managed to allow more flexibility and shared decision making and to encourage the development of school curricula that are creative, flexible, and challenging. Because restructuring looks at all aspects of schooling, it has the potential for creating an improved school environment.

Unfortunately, although some of the schools we visited were involved in intensive improvement efforts that were having a positive influence on the school environment, not all of these schools considered the HIV education program as part of this effort. It was not viewed as part of the overall effort to influence student achievement and academic success. Although these schools-in-transition were putting in place challenging curricula, strengthening instructional practices, and working to increase parent involvement, health programs—including HIV education—often seemed untouched by these advances. Ensuring that educators understand the benefits of incorporating a careful study of health programs into school improvement efforts remains a challenge for state and district staff.

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Schools that are working to create supportive environments

Visitors often feel the impact of a positive school environment. Such is the case at **Miami Southridge High School** in **Dade County, Florida,** where the interaction between staff and principal is one of mutual regard and respect. Located in a predominantly low-income neighborhood across the street from a housing project, the school has had its share of problems with crime and drugs. Despite these social problems, the school has a low dropout rate and a high attendance rate.

To let the community know that the school staff is serious about education and expects each child to excel in school, the principal designed business cards for all school staff. The cards read:

> Together We Build Academic Excellence—The Staff and Administration of Miami Southridge Senior High School are committed to: high academic standards, high expectations, equal opportunities, cultural diversity, community involvement and holistic education. The staff and administration are committed to excellence, with student success being our first priority.

In order to encourage liaisons with parents and the community, the principal decided to keep the doors of his school open from 7:00 a.m. to 6:30 p.m., Monday through Friday. The principal's enthusiasm and vision for student success carry over to the staff. According to one of the school's HIV education teachers, "Community education is first—you have to break down a lot of barriers before you can actually teach students in the classroom. You have to empower parents and tell them that it is okay to feel uncomfortable about this subject."

At **Greenway Middle School** in **Pittsburgh, Pennsylvania,** a supportive school environment includes school walls covered with brightly colored student artwork. When Greenway was first built in the early 1970s, it was a bulky octagonal building of six stories serving 1500 middle school students in six wide-open spaces. The building was accessed by six-story flights of stairs that were enclosed and difficult to monitor. Now Greenway is partitioned into smaller, more private spaces that create a better setting for learning and allow for better discipline.

Greenway draws its students from several nearby housing developments. Many are "youngsters from difficult homes—they're exposed to drugs and have the freedom to do whatever they want." Yet Greenway is a safe haven from an undisciplined and troubled environment for many of these youth. Greenway's participation in Pittsburgh's New Futures program has enabled it to implement a number of after-school activities for latchkey children. Greenway is also a teacher training center that provides districtwide staff development programs. Designed to improve the quality of school instruction through intensive, nine-week in-service programs, these classes give teachers the opportunity to improve classroom management skills, increase cultural sensitivity, refine and expand knowledge of instructional methods, and receive in-depth professional development. The presence of "master teachers" together with the New Futures program has created an environment where faculty and administrators have the special skills necessary to serve middle-school youth.

The HIV education program at Greenway reflects this environment. The program is part of a health education course taught in alternating blocks with physical education, using the same teacher for both subjects. The health curriculum emphasizes enhancing "the student's responsibility for making choices that promote and maintain good health." In keeping with the school's focus on improved learning, sex education and HIV and AIDS instruction follow a section on mental health. This allows teachers to stress that students must be mature mentally and socially before they can approach sexuality in a responsible manner. Because teachers have the same students for both health and physical education, they are able to build a trusting relationship with students before sexuality is discussed.

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CONCLUSION

Many schools are already seriously engaged in school improvement efforts, and many more soon will be. To achieve improved learning for all, schools must take into account the physical, social, and emotional health of their students as well as their intellectual needs. Comprehensive and effective school health programs that include effective HIV education contribute significantly to such efforts.

The number of states mandating HIV education increased from 17 in 1987 to 32 in 1990. Over half of these states specify that HIV education should be delivered through comprehensive school health programs. (CCSSO and NASBE, 1991) During school site visits, we found state and local educators providing effective programs for young people, especially for those who may have few other advocates. However, we also found that many programs identified as promising are still far from comprehensive, sensitive to the diversity of students, fully implemented, or effectively evaluated.

The current climate of educational reform provides an opportunity for educators to strengthen school health programs. Schools that are in the process of restructuring—attempting to redesign organizational structures and methods of teaching and learning—must seize this opportunity. Our site visits confirmed that even the most promising programs are still struggling in some areas.

Unanswered questions remain about how schools will rise to the unique challenges presented by HIV-related issues, such as teaching about safer sex, maintaining confidentiality, and determining condom availability. Other tough questions include how to find the resources and build the partnerships necessary to provide counseling and other services to students and how to ensure that school health programs meet the needs of all children and adolescents—regardless of their race, ethnicity, gender, economic status, or sexual orientation.

A fundamental reexamination of schools and schooling could help communities decide what role the school will play in answering these questions. The challenge for state and local education agencies is to marshall the resources required for schools to provide programs and services that result in healthy, well-educated students and staff.

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APPENDIX

HIGHLIGHTS OF SCHOOLS VISITED AND THE STATUS OF HIV AND HEALTH EDUCATION IN THEIR DISTRICTS[5]

[5] The information in this section was updated in 1991.

CALIFORNIA

CITY: Los Angeles

VISIT: Spring 1989

SCHOOL: David Starr Jordan High School
2265 East 103 Street
Los Angeles, California 90002

TELEPHONE: (213) 567-0531

PRINCIPAL: Grace Strauthers

GRADES SERVED: 9–12

SIZE: 1,700

SOCIOECONOMIC CHARACTERISTICS: 80% of the students come from families receiving Aid to Families with Dependent Children (AFDC). 44% of the students receive free lunch.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Hispanic—62%; Black—37%; White, Asian, and Pacific Islander—1%

HEALTH EDUCATION: All 10th graders take a semester health course taught by a credentialed health educator. That course includes a two-week unit (50 minutes a day, five days a week) on STDs.

HIV EDUCATION: HIV education is part of the health course within the unit on STDs. The unit focuses on students' sharing their concerns and feelings and on the development of self-esteem and decision-making skills. The school also participates in an HIV education week.

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CALIFORNIA

CITY:	San Diego
VISIT:	Spring 1989
SCHOOL:	La Jolla High School 750 Nautilus Street San Diego, California 92037
TELEPHONE:	(619) 454-3081
PRINCIPAL:	J. M. Tarvin
GRADES SERVED:	9–12
SIZE:	1,448
SOCIOECONOMIC CHARACTERISTICS:	Predominantly middle income
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	White—58.6%; Hispanic—30.9%; Asian—4.8%; Black—3.9%; Other—2%
HEALTH EDUCATION:	All 10th graders take a Social Concerns class taught by a credentialed health educator. That course includes a one-week unit (50 minutes a day, five days) on family life that includes STDs.
HIV EDUCATION:	The district has a sequential grade 7–12 HIV curriculum. The HIV curriculum includes a description of AIDS; how HIV is and is not transmitted; behaviors that put an individual at risk; behaviors that prevent the spread of HIV; and a discussion of the fears and myths about HIV and AIDS. The curriculum includes showing the videos "Mark and Joey," which is locally produced; "The Subject is: AIDS," narrated by Rae Dawn Chong; and "Teen AIDS in Focus."

The HIV prevention program also incorporates second-year medical students into AIDS prevention instruction and presents "Secrets," a play about HIV.

As required by state guidelines, the importance of monogamous sexual relationships and abstinence are emphasized as the only effective ways to avoid contracting or spreading the disease.

CALIFORNIA

CITY: San Diego

VISIT: Spring 1989

SCHOOL: University City High School
6949 Genesee Avenue
San Diego, California 92122

TELEPHONE: (619) 457-3040

PRINCIPAL: Mary McNaughton

GRADES SERVED: 10–12

SIZE: 1,200

SOCIOECONOMIC CHARACTERISTICS: Middle income

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Predominantly White

HEALTH EDUCATION: All 10th graders take a Social Concerns class taught by a credentialed health educator. That course includes a one-week unit (50 minutes a day, five days) on family life that includes STDs.

HIV EDUCATION: The district has a sequential grade 7–12 HIV curriculum.

The HIV curriculum includes a description of AIDS; how HIV is and is not transmitted; behaviors that put an individual at risk; behaviors that prevent the spread of HIV; and a discussion of the fears and myths about HIV and AIDS.

The curriculum includes showing the videos "Mark and Joey," which is locally produced; "The Subject is: AIDS," narrated by Rae Dawn Chong; and "Teen AIDS in Focus."

The HIV prevention program also incorporates second-year medical students into AIDS prevention instruction and presents "Secrets," a play about HIV.

As required by state guidelines, the importance of monogamous sexual relationships and abstinence are emphasized as the only effective ways to avoid contracting or spreading the disease.

CONNECTICUT

CITY: New Haven

VISIT: Spring 1989

SCHOOL: Hillhouse High School
480 Sherman Parkway
New Haven, Connecticut 06511

TELEPHONE: (203) 287-8484

PRINCIPAL: Salvatore Verderame

GRADES SERVED: 9–12

SIZE: 1,500 approximately

SOCIOECONOMIC CHARACTERISTICS: Low to middle income

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Black—98%; Other—2%

HEALTH EDUCATION: There is no required high school health course. Optional health courses are not taught by certified health educators and are not part of the HIV education program.

HIV EDUCATION: State law requires that all students receive HIV education. Each high school has a program, though the programs differ in length and teaching methodology.

HIV education is taught to all juniors and seniors for five consecutive days in required history or English classes, or in bilingual English as a second language classes by a multiracial team that includes the regular teacher, a Yale Medical School student, and a person with AIDS (PWA). The state curriculum is used, which covers basic information about HIV, including the history and

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progression of the disease; how the virus affects the immune system; transmission of the virus; myths; risky behaviors; and prevention education. HIV is also infused into other parts of the curriculum with follow-up assignments in each of the courses in which it is taught. An additional period has been added to the 9th grade that focuses on study skills, problem solving, social development, substance abuse, and HIV.

Community-based organizations (CBOs) and other agencies provide bilingual instructors, medical students for the teaching teams, and training to PWAs to prepare them to teach in the classroom. Nurses and others who operate the school-based health clinics that exist in several schools provide information about HIV to students who use the clinic services.

Dr. James Comer's Project Excel at the elementary and junior high school levels provides school-based planning and management, student support, development of decision-making skills among students, and increased parent involvement, all of which benefit the goals of the HIV education program.

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CONNECTICUT

CITY:	New Haven
VISIT:	Spring 1989
SCHOOL:	Wilbur Cross High School 181 Mitchell Drive New Haven, Connecticut 06511
TELEPHONE:	(203) 787-8728
PRINCIPAL:	John Courtmanche
GRADES SERVED:	9–12
SIZE:	1,500 approximately
SOCIOECONOMIC CHARACTERISTICS:	Low to middle income
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	Black—30–40%; Hispanic—30–41%; Asian—Less than 5%; White—The remainder
HEALTH EDUCATION:	There is no required high school health course. Optional health courses are not taught by certified health educators and are not part of the HIV education program.
HIV EDUCATION:	State law requires that all students receive HIV education. Each high school has a program, though the program may differ in length and teaching methodology. HIV education is taught to all juniors and seniors for five consecutive days in required history or English classes, or in bilingual English as a second language classes by a multiracial team that includes the regular teacher, a Yale Medical School student, and a person with AIDS (PWA). The state curriculum is used, which covers basic information about HIV, including the history and

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progression of the disease; how the virus affects the immune system; transmission of the virus; myths; risky behaviors; and prevention education. HIV is also infused into other parts of the curriculum with follow-up assignments in each of the courses in which it is taught. An additional period has been added to the 9th grade that focuses on study skills, problem solving, social development, substance abuse, and HIV.

Community-based organizations (CBOs) and other agencies provide bilingual instructors, medical students for the teaching teams, and training to PWAs to prepare them to teach in the classroom. Nurses and others who operate the school-based health clinics that exist in some schools provide information about HIV to students who use the clinic services.

Dr. James Comer's Project Excel at the elementary and junior high school levels provides school-based planning and management, student support, development of decision-making skills among students, and increased parent involvement, all of which benefit the goals of the HIV education program.

FLORIDA

CITY:	Miami
VISIT:	Winter 1990
SCHOOL:	Miami Southridge High School 19355 S.W. 114 Avenue Miami, Florida 33157
TELEPHONE:	(305) 238-6110
PRINCIPAL:	Frederick Rogers
GRADES SERVED:	9–12
SIZE:	3,126
SOCIOECONOMIC CHARACTERISTICS:	The school is located in a predominantly low-income neighborhood. 13.5% of the students participate in the free and reduced price lunch programs.
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	Black—39%; White—31%; Hispanic—22%; Asian—2%; Other—approximately 6%
HEALTH EDUCATION:	The district's state-mandated and state-funded comprehensive health program includes health instruction, health services, and a healthy school environment. Students take a full semester of health in the 10th grade.
HIV EDUCATION:	HIV instruction is provided by certified health teachers in the health course at the high school level. School Board passed legislation April 1991 that required all school districts to provide a K–12 HIV education program.

FLORIDA

CITY:	Sarasota
VISIT:	Winter 1990
SCHOOL:	Riverview High School 1 Ram Way Sarasota, Florida 34231
TELEPHONE:	(813) 923-1484
PRINCIPAL:	Edward Brown Dr. Arthur Williams (Present Principal)
GRADES SERVED:	9–12
SIZE:	2,290
SOCIOECONOMIC CHARACTERISTICS:	Middle to upper income
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	Predominantly White
HEALTH EDUCATION:	In 1977 the district adopted the state mandate for comprehensive health education. A Life Skills Management course is taught in the elementary, middle, and high schools by certified health educators. It is required for high school graduation.
HIV EDUCATION:	HIV education is provided in the 5th, 8th, 9th, and 10th grades. It is part of the STDs unit of the Life Skills Management course. In addition to classroom instruction, HIV education programs include drama, puppetry, peer education, individual rap sessions, and participation in a communitywide "HIV Awareness Week." Peers are trained at weekend retreats to deliver the educational components.

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FLORIDA

CITY:	Sarasota
VISIT:	Winter 1990
SCHOOL:	Sarasota High School 1001 South Tamiami Trail Sarasota, Florida 34236
TELEPHONE:	(813) 955-0181
PRINCIPAL:	Raymond Raimone
GRADES SERVED:	9–12
SIZE:	2,400
SOCIOECONOMIC CHARACTERISTICS:	Middle to upper income
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	Predominantly White
HEALTH EDUCATION:	In 1977 the district adopted the state mandate for comprehensive health education. A Life Skills Management course is taught in the elementary, middle, and high schools by certified health educators. It is required for high school graduation.
HIV EDUCATION:	HIV education is provided in the 5th, 8th, 9th, and 10th grades. It is part of the STDs unit of the Life Skills Management course. In addition to classroom instruction, HIV education programs include drama, puppetry, peer education, individual rap sessions, and participation in a communitywide "HIV Awareness Week."

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MARYLAND

CITY: Baltimore

VISIT: Spring 1989

SCHOOL: Gardenville Elementary School
5300 Belair Road
Baltimore, Maryland 21206

TELEPHONE: (410) 396-6382

PRINCIPAL: Carolyn Dawson

GRADES SERVED: K–5

SIZE: 375

SOCIOECONOMIC CHARACTERISTICS: Middle to low income (50% receive free lunch)

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: White—70%; Black—30%

HEALTH EDUCATION: 12 weeks of health per year (3 weeks each quarter).

HIV EDUCATION: The district adheres to the Maryland State Board of Education bylaw requiring that HIV be taught at least once in grades 3–6, 6–9, and 9–12.

At the elementary level, HIV is taught in grades 3–5 as part of the curriculum. The HIV curriculum consists of a minimum of 3 lessons that are augmented by print and media resources.

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MARYLAND

CITY: Baltimore

VISIT: Spring 1989

SCHOOL: Lakeland Middle School
2921 Stranden Road
Baltimore, Maryland 21230

TELEPHONE: (410) 396-1406

PRINCIPAL: William Shaw
Elizabeth Williams (Present Principal)

GRADES SERVED: Pre-Kindergarten–2 and 6–8

SIZE: 552 (Elementary 209—Middle 343)

SOCIOECONOMIC CHARACTERISTICS: 256 students receive free lunch, another 40 receive a reduced price lunch.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Pre-K through 2: White—72%; Black—28%.
6–8: Black—65%; White—34%; Other—1%

HEALTH EDUCATION: The middle school curriculum includes health.

HIV EDUCATION: The district adheres to the Maryland State Board of Education bylaw that requires that HIV be taught at least once in grades 3–6, 6–9, and 9–12.

In the middle schools (grades 6–8), HIV education is taught for a minimum of five days during a semester of health. In 7th grade health is part of the life science curriculum that is delivered over two semesters. HIV education is also infused into other courses in grades 6–8.

At the high school level (grades 9–12) HIV is taught in all science courses for a minimum of three days. (Three years of science are required for graduation.)

MARYLAND

CITY: Forestville

VISIT: Spring 1989

SCHOOL: Forestville High School
7001 Beltz Drive
Forestville, Maryland 20747

TELEPHONE: (301) 420-4000

PRINCIPAL: Arthur Curry

GRADES SERVED: 9–12

SIZE: 960

SOCIOECONOMIC CHARACTERISTICS: 14% of the students qualify for free or reduced price lunch.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Black—95%; White—4%; Hispanic—1%

HEALTH EDUCATION: Health is required at the high school level.

HIV EDUCATION: The district adheres to the Maryland State Board of Education bylaw that requires that HIV be taught at least once in grades 3–6, 6–9, and 9–12.

HIV education is part of a one-semester health course in the high schools. It is taught in three days as part of the unit on sexually transmitted diseases and infused into other parts of the health curriculum.

A peer education program provides drug counseling and might be expanded to include HIV and pregnancy concerns.

MASSACHUSETTS

CITY: Boston

VISIT: Spring 1990

SCHOOL: East Boston High School
86 White Street
Boston, Massachusetts 02128

TELEPHONE: (617) 567-2140

PRINCIPAL: John Poto

GRADES SERVED: 9–12

SIZE: 731

SOCIOECONOMIC CHARACTERISTICS: Predominantly middle to lower middle income; 20% of the students are eligible for free lunch.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: White—62%; Black—24%; Hispanic—8%; Asian—5%; Native American—1%

HEALTH EDUCATION: The Boston Public Schools require one semester of health at the high school level. However, many elementary and middle schools provide health courses as well. Middle schools often teach health in science classes. Boston developed K–12 comprehensive health education objectives based on recommendations given by the state to implement school health education programs. There is an approved human sexuality curriculum for the middle and high schools. Substance abuse and violence prevention teacher training is offered to teachers and staff at all grade levels. Peer leadership programs are active in 16 schools.

HIV EDUCATION: In the Boston Public Schools, HIV education is mandated in grades 6–12. Three grade-level curricula were developed during the first year of

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funding from the Centers for Disease Control.

Teacher training has been provided for teachers from every school in the system with grades 6–12. Teachers (from many subject areas) have been trained in AIDS 101 and in a variety of HIV and sexuality-related topics. Special education and English as a second language teachers have been offered additional training. Substance abuse prevention training is also offered throughout the system. The HIV/AIDS education program includes an ongoing "Persons With AIDS" (PWA) education component and peer leadership training.

With the assistance of the Department of Health and Hospitals, many community resources enhance health education programs such as school health fairs and health wellness weeks. East Boston High School and Rogers Middle School participated in a pilot HIV/AIDS program that concentrated on integrating HIV/AIDS education into comprehensive health.

At present, a Special Education Teachers' Guide is under development and the pilot elementary 4th 5th grade HIV curriculum is being evaluated and revised.

Fourteen elementary schools are involved in piloting HIV/AIDS education.

Parent education has been a part of this program since its inception, with outreach to the community outside of the schools as well.

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MASSACHUSETTS

CITY:	Boston
VISIT:	Spring 1990
SCHOOL:	Rogers Middle School 15 Everette Street Boston, Massachusetts 02720
TELEPHONE:	(617) 361-1990
PRINCIPAL:	John T. Daniels
GRADES SERVED:	6–8
SIZE:	468
SOCIOECONOMIC CHARACTERISTICS:	Predominantly middle income
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	Black—73%; White -19%; Hispanic—6%; Asian—1%; Native American—less than 1%
HEALTH EDUCATION:	In the Boston Public Schools, only one semester of health is required, and it is required only at the high school level. However, many elementary and middle schools provide health courses as well. Middle schools often teach health in science classes. Boston developed K–12 comprehensive health education objectives based on recommendations given by the state to implement school health education programs. There is an approved human sexuality curriculum for the middle and high schools. Teacher training in substance abuse and violence prevention is offered to teachers and staff at all grade levels. Peer leadership programs are active in 16 schools.
HIV EDUCATION:	In the Boston Public Schools, HIV education is mandated in grades 6–12. Three grade-level

curricula were developed during the first year of funding from the Centers for Disease Control.

Teacher training has been provided for teachers from every school in the system with grades 6–12. Teachers (from many subject areas) have been trained in AIDS 101 and in a variety of HIV and sexuality-related topics. Special education and English as a second language teachers have been offered additional training. Substance abuse prevention training is also offered throughout the system. The HIV AIDS education program includes an ongoing "Persons With AIDS" (PWA) education component and peer leadership training.

With the assistance of the Department of Health and Hospitals, many community resources enhance health education programs such as school health fairs and health/wellness weeks. East Boston High School and Rogers Middle School participated in a pilot HIV AIDS program that concentrated on integrating HIV AIDS education into comprehensive health.

At present, a Special Education Teachers' Guide is under development and the pilot elementary 4th/5th grade HIV curriculum is being evaluated and revised.

Fourteen elementary schools are involved in piloting HIV AIDS education.

Parent education has been a part of this program since its inception, with outreach to the community outside of the schools as well.

NEW JERSEY

CITY:	Passaic
VISIT:	Winter 1990
SCHOOL:	Lincoln Middle School Broadway and Boulevard Passaic, New Jersey 07055
TELEPHONE:	(201) 470-5504
PRINCIPAL:	Louis Freda
GRADES SERVED:	7–8
SIZE:	1,300
SOCIOECONOMIC CHARACTERISTICS:	70% of the students are eligible for free lunch.
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	Hispanic—62%; Black—30%; East Indian and Asian—5%; White—3%
HEALTH EDUCATION:	The state has mandated that HIV education be offered within a comprehensive K–12 health education program.
HIV EDUCATION:	In grades 6–12 HIV education is part of the STDs unit in family life/health education, in drug and alcohol education, in science classes, and in counseling with students. A health educator from the City Department of Human Resources helps teach these classes, prepares HIV lesson plans, and provides materials for HIV education in grades 2–6. Also, American Red Cross has provided materials and in-service workshops for teachers of grades K–12.

NEW JERSEY

CITY:	Passaic
VISIT:	Winter 1990
SCHOOL:	Passaic High School 170 Paulison Avenue Passaic, New Jersey 07055
TELEPHONE:	(201) 470-5614
PRINCIPAL:	Marjorie Bunnel
GRADES SERVED:	9–12
SIZE:	2,050
SOCIOECONOMIC CHARACTERISTICS:	152 welfare recipients; 901 students receive free lunch; a significant number of illegal aliens.
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	Hispanic—62%; Black—30%; Asian—5%; and White—3%
HEALTH EDUCATION:	The state has mandated that HIV education be offered within a comprehensive K–12 health education program.
HIV EDUCATION:	In grades 6–12 HIV education is part of the STDs unit in family life/health education, in drug and alcohol education, in science classes, and in counseling with students. A health educator from the City Department of Human Resources helps teach these classes, prepares HIV lesson plans, and provides materials for HIV education in grades 2–6. Also, American Red Cross has provided teaching materials and in-service training for teachers of grades K–12.

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NEW YORK

CITY: New York

VISIT: Spring 1989

SCHOOL: Raphael Cordero Bilingual School
Junior High School #45
2351 First Avenue
New York, New York 10035

TELEPHONE: (212) 860-6609

PRINCIPAL: Nilda Rios, Director

GRADES SERVED: 7–9

SIZE: 250

SOCIOECONOMIC CHARACTERISTICS: Total school population eligible for free or reduced price lunch.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Hispanic—97%; Black—3%

HEALTH EDUCATION: The junior high school program includes three health lessons per week at the 8th grade level.

HIV EDUCATION: As required by the state, the district provides HIV education at the elementary, middle, and high school levels within the context of a health course. In Community District 4, which includes Raphael Cordero Bilingual School, a team of health educators, drop-out prevention specialists, and others plan the HIV education program under the leadership of the Office of Student Development.

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NORTH CAROLINA

CITY: Charlotte

VISIT: Spring 1989

SCHOOL: McClintock Junior High School
2101 Rama Road
Charlotte, North Carolina 28212

TELEPHONE: (704) 379-7175

PRINCIPAL: Jim Cockerham
Joel Ritchie (Present Principal)

GRADES SERVED: 7–9

SIZE: 1,150

SOCIOECONOMIC CHARACTERTISTICS: Upper income and lower income

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: White—67%; Black—31%; Hispanic and Asian—2%

HEALTH EDUCATION: A full semester of health is required for all 7th and 8th grade students and a quarter of health is required for all 9th grade students. The health curriculum is comprehensive, including topics such as family living/human sexuality, pregnancy, drug education, and communicable diseases.

HIV EDUCATION: Under a state mandate, the district teaches HIV prevention in grades 7–12. At the secondary level, HIV is taught only by teachers certified to teach health.

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PENNSYLVANIA

CITY:	Philadelphia
VISIT:	Spring 1989
SCHOOL:	Benjamin Franklin High School Broad and Green Streets Philadelphia, Pennsylvania 19130
TELEPHONE:	(215) 568-7701
PRINCIPAL:	Norman K. Spencer
GRADES SERVED:	9–12
SIZE:	1,004
SOCIOECONOMIC CHARACTERISTICS:	55% of the students are eligible for free lunch.
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	Black—96%; Hispanic—3%; White—1%
HEALTH EDUCATION:	All 10th and 11th graders take a semester of health education as a graduation requirement.
HIV EDUCATION:	As required by state law, the district provides HIV education once at every level of education—in the elementary school, middle school, and high school. The HIV program is integrated into the K–12 health curriculum. Schools select from several options and develop their own programs to meet the minimum requirements.

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PENNSYLVANIA

CITY: Pittsburgh

VISIT: Spring 1989

SCHOOL: Greenway Middle School
1400 Crucible Street
Pittsburgh, Pennsylvania 15205

TELEPHONE: (412) 928-2800

PRINCIPAL: Lloyd Briscoe
William Brim (Present Principal)

GRADES SERVED: 6–8

SIZE: 817

SOCIOECONOMIC CHARACTERISTICS: 59.3% participate in the free lunch program.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Black—47%; Other—53%

HEALTH EDUCATION: Middle school students receive 24 class periods of health each year.

HIV EDUCATION: As required by the state, HIV education is provided at least once at the elementary, middle, and high school levels.

Wellness Curriculum for grades 6–8 includes the following HIV lessons, which are covered in 2–10 days:

- definition of HIV and AIDS
- cause of AIDS
- the immune system
- stages of HIV infection and AIDS
- how HIV is and is not transmitted
- high-risk behavior

PENNSYLVANIA

CITY: Pittsburgh

VISIT: Spring 1989

SCHOOL: Schenley High School
Bigelow Boulevard and Central Avenue
Pittsburgh, Pennsylvania 15213

TELEPHONE: (412) 622-8200

PRINCIPAL: John Young
Normandy Fulson (Present Principal)

GRADES SERVED: 9–12

SIZE: 948

SOCIOECONOMIC CHARACTERISTICS: 32.9% participate in the free lunch program.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Black—61%; Other—39%

HEALTH EDUCATION: Students take two semesters of health, usually in the 9th grade, and in the 11th or 12th grade.

HIV EDUCATION: As required by the state, HIV education is provided at least once at the elementary, middle, and high school levels.

The high school health classes use the Wellness Curriculum for Secondary Schools. It includes the following HIV lessons, which are covered in 2–10 days:

- definition of HIV and AIDS
- cause of AIDS
- the immune system
- stages of HIV infection and AIDS
- how HIV is and is not transmitted
- high-risk behavior

WASHINGTON

CITY: Seattle

VISIT: Spring 1989

SCHOOL: Garfield High School
400 23rd Avenue
Seattle, Washington 98122

TELEPHONE: (206) 281-6040

PRINCIPAL: Perry Wilkins

GRADES SERVED: 9–12

SIZE: 1,209

SOCIOECONOMIC CHARACTERISTICS: *Not Available at Time of Visit.*

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Minorities—51%; White—49%

HEALTH EDUCATION: One semester of health is required at the high school level.

HIV EDUCATION: State law requires that the district provide HIV education in every grade from 5th through 12th, using a locally developed plan and a curriculum approved by the state health agency.

Students in the district receive HIV education in social studies, physical education, health, and language arts classes, assemblies, clubs, and related activities.

WASHINGTON

CITY:	Seattle
VISIT:	Winter 1990
SCHOOL:	Hamilton Middle School 1610 North 41st Street Seattle, Washington 98103
TELEPHONE:	(206) 281-6130
PRINCIPAL:	Dave Stevens Al Nakano (Present Principal)
GRADES SERVED:	6–8
SIZE:	620
SOCIOECONOMIC CHARACTERISTICS:	36% of the students qualify for free or reduced price lunch.
RACIAL/ETHNIC MAKE-UP OF STUDENT BODY:	White—60%; Black—15%; Asian—13%; Hispanic—8%; Native American—4%
HEALTH EDUCATION:	Middle schools may choose to offer health as an elective or required course. At Hamilton, it is an elective.
HIV EDUCATION:	State law requires that the district provide HIV education in every grade from 5th through 12th, using a locally developed plan and a curriculum approved by the state health agency. Students receive HIV education in social studies, physical education, health, and language arts classes, assemblies, clubs, and related activities.

WASHINGTON

CITY: Seattle

VISIT: Winter 1990

SCHOOL: Roosevelt High School
1410 North East 66th Street
Seattle, Washington 98115

TELEPHONE: (206) 281-6050

PRINCIPAL: Joan Roberson

GRADES SERVED: 9–12

SIZE: 1,297

SOCIOECONOMIC CHARACTERISTICS: 226 are on free/reduced lunch.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Minority—586; White—705

HEALTH EDUCATION: One semester of health is required at the high school level.

HIV EDUCATION: State law requires that the district provide HIV education in every grade from 5th through 12th, using a locally developed plan and a curriculum approved by the state health agency.

Students receive HIV education in social studies, physical education, health, and language arts classes, assemblies, clubs, and related activities.

WISCONSIN

CITY: Milwaukee

VISIT: Spring 1990

SCHOOL: Parkman Middle School
3620 North 18th Street
Milwaukee, Wisconsin 53206

TELEPHONE: (414) 445-9930

PRINCIPAL: Dennis Schumacher
Ken Holt (Present Principal)

GRADES SERVED: 6–8

SIZE: 600

SOCIOECONOMIC CHARACTERISTICS: Predominantly one-parent families; 81% are eligible for free or reduced lunch.

RACIAL/ETHNIC MAKE-UP OF STUDENT BODY: Black—99%; Other—1%

HEALTH EDUCATION: Health is a separate course in the 7th and 8th grades. In the 9th and 10th grades, health is required and taught by a certified health educator.

HIV EDUCATION: HIV education is provided in health education. A city health department educator works with the health teachers and provides information about STDs and AIDS.

During the spring of 1991, the local education agency implemented a trainers of trainers program for HIV education. The American Red Cross certified 16 teachers to train teachers at all levels and provided them with technical assistance. The local education agency disseminated an HIV resource packet. The

resource packet is available in K–3, 4–6, 6–8, and 9–12 series. Each packet contains learner outcomes and conveys general information about AIDS and psychosocial issues surrounding HIV infection and AIDS. The school district will combine the discussion of the psychosocial issues surrounding AIDS with the guidance curriculum. Trainers will help teachers develop lesson plans from materials in the resource packet.

Council of Chief State School Officers
Resource Center on Educational Equity
One Massachusetts Avenue, N.W., Suite 700
Washington, D.C. 20001
(202) 408-5505